MARKET CONDUCT EXAMINATION

COMMUNITY HEALTH PLAN OF WASHINGTON

720 OLIVE WAY, SUITE 300
SEATTLE, WASHINGTON 8101

January 1, 2003 – June 30, 2004

Order No. G 05-73
Community Health Plan of Washington
Exhibit A

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The Honorable Mike Kreidler
Washington State Insurance Commissioner
P.O. Box 40255
Olympia, Washington 98504

Dear Commissioner Kreidler:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.44.145 and procedures promulgated by the National Association of Insurance Commissioners and the Office of the Insurance Commissioner (OIC), an examination of the market conduct affairs has been performed of:

Community Health Plan of Washington, NAIC #47049
720 Olive Way, Suite 300
Seattle, Washington 98101

In this report, Community Health Plan of Washington is referred to as CHPW or as the Company.

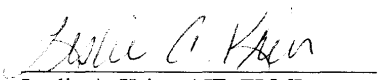
This report of examination is respectfully submitted.

CHIEF EXAMINER'S REPORT CERTIFICATION and ACKNOWLEDGEMENTS

This examination was conducted in accordance with Office of Insurance Commissioner and National Association of Insurance Commissioners market conduct examination procedures. Nancy L. Campbell, AIE, ACS and George J. Lazur, CIE, CPCU of the Washington State Office of Insurance Commissioner performed this examination and participated in the preparation of this report.

The examiners wish to express appreciation for the courtesy and cooperation extended by the personnel of Community Health Plan of Washington during the course of this market conduct examination.

I certify that this document is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of Insurance Commissioner and that this report is true and correct to the best of my knowledge and belief.



Leslie A. Krier, AIE, FLMI
Chief Market Conduct Examiner
Office of the Insurance Commissioner
State of Washington

FOREWORD

This examination was completed by applying tests to each examination standard. Each test applied during the examination is stated in this report and the results are reported. Exceptions are noted as part of the comments for the applied test. Throughout the report, where cited, RCW refers to the Revised Code of Washington, and WAC refers to Washington Administrative Code.

Scope

Time Frame

The examination covered the Companies' operations from January 1, 2003 through June 30, 2004. This was the first market conduct examination of Community Health Plan of Washington. This examination was performed in the Seattle OIC office.

Matters Examined

The examination included a review of the following areas:

Company Operations and Management	Claims
Complaints	Underwriting
Provider Activity	

Sampling Standards

Methodology

In general, the sample for each test utilized in this examination falls within the following guidelines:

92 %	Confidence Level
+/- 5 %	Mathematical Tolerance.

Regulatory Standards

Market conduct samples are tested for compliance with standards established by the OIC. The tests applied to sampled data will result in an error ratio, which determines whether or not a standard is met. If the error ratio found in the sample is, generally, less than 5%, the standard will be considered as met. The standards in the area of agent licensing and appointment, and policy and form filings will not be met if any violation is identified. This will also apply when all records are examined, in lieu of a sample.

For those standards, which look for the existence of written procedures, or a process to be in place, the standard will be met based on the examiner's analysis of those procedures or

processes. The analysis will include a determination of whether or not the company follows established procedures.

Standards will be reported as Passed (without Comment), Passed with Comment or Failed. The definition of each category follows:

Passed	There were no findings for the standard.
Passed with Comment	Errors in the records reviewed fell within the tolerance level for that standard.
Failed	Errors in the records reviewed fell outside of the tolerance level established for the standard.

COMPANY OPERATIONS AND MANAGEMENT

Company History

Community Health Plan of Washington (CHPW) was established in 1992 by a network of community and migrant health centers across Washington State. CHPW, as Community Health Plan, operated as a subcontractor under the health care service contractor license of Blue Cross of Washington and Alaska from 1995 through 1996. The Company was issued a certificate of registration by the Office of the Insurance Commissioner on August 16, 1996. Community Health Plan of Washington is a wholly owned subsidiary of Community Health Network of Washington (CHNW). CHNW is a nonprofit managed health care delivery network that is operated under the direction of 19 community and migrant health centers (Centers), as well as the parent company of CHPW. CHNW is comprised of the clinics operated by these Centers and other clinics within CHNW's service area.

Company Management & Operations

The Company is managed by a Board of Directors. The current members of the board are:

Board Member/ Position/ Representation	Company/ Community Affiliation	Original Appointment Date	Term Expires
David E. Flentge, Chair	Community Health Care	10/1/2004	12/2007
Thomas J. Trompeter, Treasurer	CHC's of King County	10/1/2004	12/2006
Linda M. McVeigh, Secretary	Country Doctor, CHC	10/1/2004	12/2006
John F. Browne, Board Member	Moses Lake CHC	10/1/2004	12/2007
Juan C. Olivares, Board Member	Yakima Valley Farm Workers Clinic	10/1/2004	12/2005
Mark L. Secord, Board Member	Puget Sound Neighborhood HC	10/1/04	12/2005
Peggy J. Hopkins, Board Member	Community Health Association of Spokane	10/1/04	12/2005
Shakti K. Matta, M.D., Board Member	Columbia Basin Health Association	10/1/04	12/2006

Territory of Operations

During the examination period, CHPW operated in 32 counties in Washington State. The Company operates in these counties: Adams, Benton, Chelan, Clark, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom and Yakima.

Findings

Company Operations and Management Standard #2 is not applicable to this examination. The market conduct examiners did not review the minutes of the Board of Directors meetings. However, board meeting minutes were reviewed as part of the OIC's financial examination for the period January 1, 1999 through December 31, 2003. The review by the financial examiners found that the minutes of the meetings of stockholders, directors, and committees adequately approved and support the Company's transactions and events.

The following Company Operations & Management Standards passed without comment:

	Company Operations & Management Standard	Reference
1	**The company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington.**	**RCW 48.44.015(1)**
3	**When the company registers with the OIC, it is required to state its area of operations.**	**RCW 48.44.040**

GENERAL EXAMINATION FINDINGS

The Company's records and operations were reviewed to determine if the Companies do business in accordance with the requirements of this state.

Findings

The following General Examination Standards passed without comment:

#	General Examination Standards	Reference
1	**The company does business in good faith, and practices honesty and equity in all transactions.**	**RCW 48.01.030**
2	**The company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request.**	**RCW 48.44.145(2)**
3	**The company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC.**	**WAC 284-30-572(2)**

CLAIMS

Claims Processing Manual

The Company provided copies of the Adaptis Claims Adjudication Manual and the Harrington Claims Adjudication Manual. The procedures are very detailed for various medical conditions and situations. The procedures are consistent and non-discriminatory.

Claims Processing

Prior to January 1, 2004, Adaptis, Inc., a wholly owned subsidiary of CHPW, provided third party administrative services for all claims for members enrolled with CHPW. On January 1, 2004, CHPW contracted with Harrington Business Services, Inc. (HBSI) to provide third party administrative services to Public Employees Benefits Board (PEBB) members enrolled with CHPW. Adaptis continues to provide third party administrative services to all members other than PEBB.

Claims Review

There were 1,504,542 (98.1%) claims processed by Adaptis during the examination period.

- Paid 1,341,246
- Denied 161,094
- Suspended 2,202

There were 29,018 (1.9%) claims processed by HBSI during the examination period.

- Paid 25,940
- Denied 3,078

There were 37,246 paid claims that included interest payments.

- Adaptis 37,072
- Harrington 174

Due to a major computer hardware and software upgrade in the first quarter of 2003, there were 27,936 Adaptis claims that included interest payments. After the system upgrade was completed, the number of claims requiring interest payments decreased significantly each quarter:

- 2nd Quarter 2003: 5,730
- 3rd Quarter 2003: 2,829
- 4th Quarter 2003: 357
- 1st Quarter 2004: 220

The examiners selected a claim sample from the total number of denied claims and the claims that required interest payments. The following were selected:

TPA	Claim Type	# of Claims	Sample Selected	# of Claims Reviewed
Adaptis	Denied	161,094	80	71*
	Interest Paid	37,072	80	80
Harrington	Denied	3,078	20	20
	Interest Paid	174	20	20
Total		**201,418**	**200**	**191**

*Nine (9) Adaptis claims were for Basic Health Plan benefits and were outside the scope of the examination.

Findings

The following Claims Standards passed without comment:

#	Claims Standards	Reference
1	**The company shall provide no less than urgent and emergent care to a child who does not reside in the company's service area.**	**RCW 48.01.235(3)**
2	**The company shall not retrospectively deny emergency or nonemergency care that had prior authorization.**	**RCW 48.43.525(1)**
3	**The company shall not retrospectively deny an individual prescription drug claim that had prior authorization.**	**RCW 48.44.465**
4	**The company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefit if services were performed by a dentist.**	**RCW 48.43.180, RCW 48.44.500**
5	**The company shall pay or deny 95% of all claims within sixty (60) days of receipt. The company pays interest on denied and unpaid clean claims that are more than 61 days old.**	**WAC 284-43-321(2)**
6	**The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied.**	**WAC 284-43-321(4)**
7	**The company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined.**	**RCW 48.43.520, WAC 284-43-410**
8	**The company administers coordination of benefits provisions as required.**	**Chapter 284-51 WAC**
9	**All plans must provide female enrollees direct access to women's health care services.**	**RCW 48.42.100, WAC 284-43-250**

#	Claims Standards	Reference
10	All plans shall cover emergency services necessary to screen and stabilize a covered person.	RCW 48.43.093
11	Decisions concerning maternity care and services are to be made between the mother and the provider.	RCW 48.43.115
12	An enrollee may receive benefits at a long term care facility if he/she was a resident prior to hospitalization.	RCW 48.43.125
13	All plans must include coverage for diabetes.	RCW 48.44.315
14	All plans must include coverage for mammograms.	RCW 48.44.325, WAC 284-44-046
15	All plans must include coverage for reconstructive breast surgery.	RCW 48.44.330
16	All plans shall waive preauthorization for mental health treatment if member is involuntarily committed to a state mental hospital.	RCW 48.44.342
17	All plans must provide coverage for the formula necessary for the treatment of phenylketonuria (PKU).	RCW 48.44.440, WAC 284-44-450
18	All group plans shall provide benefits for the treatment of chemical dependency. All contract benefits for the treatment of chemical dependency must comply with the specified standards.	RCW 48.44.240, Chapter 284-53 WAC
19	All group plans must provide benefits for prenatal diagnosis of congenital disorders.	RCW 48.44.344
20	All group plans must provide coverage for neurodevelopmental therapies for individuals age 6 and under.	RCW 48.44.450
21	All individual health benefit plans offered or renewed after October 1, 2000 shall include maternity and prescription drug benefits.	RCW 48.43.041
22	All plans must include every category of provider.	RCW 48.43.045, WAC 284-43-205

COMPLAINTS

Complaint Handling Procedures

The Company provided the examiners with a copy of its grievance procedures that were in use during the examination period. The procedures include four (4) levels of process:

- First Level Appeal: A request for reconsideration of a decision that has been made.
- Second Level Appeal: A request for additional reconsideration the decision reached after a First Level Appeal.
- Complaint: An expression of dissatisfaction of service.

- Independent Review Organization (IRO): A request for review of an adverse determination by an organization outside of CHPW.

The Company also provided copies of its grievance audits for the examination period. The audits covered timelines, turnaround detail, and quality of work reviews of urgent appeals, regular appeals, and complaints. The examiners noted that regular appeals and complaints fell below the Company's processing standards in seven (7) of the 18 months in the examination period. As a result of the internal auditing, CHPW recognized deficiencies in its procedures. Grievance and appeal policies were issued on October 1, 2003. These policies contain a clear outline of the timelines required for response and processing. During the last three (3) months of the examination period, the Company's audits show improvement and internal performance measures were met.

Company Complaint File Review

The member grievance log submitted by the Company contained 1,786 items for the examination period: 1,784 submitted by members and two (2) submitted by the Department of Social & Health Services (DSHS). The 1,784 submitted by members consisted of:

- First Level 506
- Second Level* 31
- Complaint 1,243
- Independent Review Organization (IRO) 4

*Second level appeals are originally classified as first level appeals. When a second level appeal is requested, the first level appeal file is retrieved, reopened, and the classification of grievance is changed.

A random sample of 50 files was selected for review. The following is a breakdown of the categories and number of files selected from each:

- First Level 17
- Second Level 2
- Complaint 27
- IRO 4

Five (5) of the files selected in the sample concerned coverage under the Basic Health Plan. These files were outside the scope of the examination and were not reviewed. The following chart shows the reasons and disposition of the 45 files that were reviewed:

Type	Number	Overturned/ Resolved	%	Upheld	%
Claim Handling	1	0	0%	1	100%
Benefits	15	10	66.7%	5	33.3%

Referrals	9	4	44.4%	5	55.6%
Enrollment (Eligibility, ID Cards, Information)	10	10	100%	0	0%
Provider Services (PCP Selection, Clinic Contact, Record Transfer, Network Adequacy)	10	10	100%	0	0%
Total	**45**	**34**	**75.6%**	**11**	**24.4%**

The majority of the complaints and grievances that were overturned concerned enrollment and provider services. Company personnel explained that due to the demographics of its business and its interaction with government programs, delays do occur in the enrollment process, as well as the selection or assignment of primary care physicians.

OIC Complaint Review

There were ten (10) complaints filed with the OIC during the examination period. Five complaints involved Basic Health Plan (BHP) coverage. These complaints are outside the scope of the examination. The five (5) remaining complaints were reviewed by the examiners. The Company records were consistent with the OIC records and were complete and accurate.

Findings

The following Complaints Standards passed without comment:

#	Complaints Standards	Reference
1	**The company has filed a copy of its procedures for review and adjudication of complaints with the OIC.**	**RCW 48.43.055**
2	**The company maintains a fully operational, comprehensive grievance process.**	**RCW 48.43.530**
3	**The company provides enrollees access to independent review services to resolve disputes.**	**RCW 48.43.535**
4	**Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC.**	**WAC 284-30-650, Technical Advisory T 98-4**
5	**The company complies with procedures for health care service review decisions.**	**WAC 284-43-620**

UNDERWRITING

Because of the nature of the Company's business, the examiners did not review samples of underwriting files. Rather, the examiners reviewed the Company's policies and procedures regarding eligibility and enrollment. The policies and procedures are comprehensive and demonstrate the Company's intent to follow statutes and regulations during the underwriting process.

The following Underwriting Standards passed without comment:

#	Underwriting Standards	Reference
1	**The company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent.**	**RCW 48.01.235, RCW 48.44.212**
2	**The company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage.**	**RCW 48.43.015, WAC 284-43-710**
3	**The company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The company shall accept any state resident within the group and within the Company's service area.**	**RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720**
4	**Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24).**	**RCW 48.43.028**
5	**Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap.**	**RCW 48.44.200, RCW 48.44.210**
6	**All plans shall cover newborn infants and congenital anomalies from the moment of birth.**	**RCW 48.44.212(1)**
7	**No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap.**	**RCW 48.44.220**
8	**The company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five (5) years prior.**	**RCW 48.44.335**
9	**Adoptive children shall be covered on the same basis as other dependents.**	**RCW 48.44.420**
10	**An individual is not required to complete the standard health questionnaire if stated criteria are met. *Individual Coverage Only***	**RCW 48.43.018(1)**

#	Underwriting Standards	Reference
11	**The company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application.** ***Individual Coverage Only***	**RCW 48.43.018(2)(b)**
12	**All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action.** ***Individual Coverage Only***	**RCW 48.44.260**
13	**A rider will be cancelled upon application by the enrollee if, at least five (5) years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider.** ***Individual Coverage Only***	**RCW 48.44.430**
14	**Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee.**	**RCW 48.44.400**
15	**All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required.**	**RCW 48.44.460, WAC 284-44-042**
16	**An individual may return an individual health care contract for a full refund within ten (10) days of its delivery if not satisfied with the contract for any reason.**	**RCW 48.44.230**

RATE AND FORM FILING

Rate and Form Filing Review

The Company rate and form filing log contained 13 forms that were filed during the examination period. All of the forms were approved by the OIC.

Rate and Form Filing Standard #2 is not applicable to this examination. Since the Company only writes government-sponsored plans, its rates are provided by the government programs and cannot be changed by the Company.

Findings

The following Rate and Form Filing Standards passed without comment:

#	Rate and Form Filing Standards	Reference
1	**All contract forms have been filed with and approved by the Office of Insurance Commissioner prior to use.**	**RCW 48.44.040, WAC 284-43-920**
3	**All contract forms and rates have been filed with the Office of Insurance Commissioner on transmittal forms prescribed by and available for the Commissioner.**	**WAC 284-43-925**

PROVIDER ACTIVITY

Provider Contracting Procedures

The examiners reviewed the Company's provider contracting procedures. The procedures comply with all regulatory requirements.

Provider Directories

The examiners reviewed copies of the 2003 and 2004 provider directories. The directories include providers, facilities, and pharmacies within the Company's stated territory of operations.

Provider Activity Review

The Company filed 17 provider contract forms during the examination period. Four (4) of the forms were reviewed. The examiners also reviewed the Company's listing of network adequacy filings.

Findings

The following Provider Activity Standards passed without comment:

#	Provider Activity Standards	Reference
1	**All provider contract forms must be filed with and approved by the OIC prior to use.**	**RCW 48.44.070, WAC 284-43-330**
2	**All provider contract forms must contain and adhere to the prescribed standards.**	**WAC 284-43-320 through WAC 284-43-340**
3	**All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers.**	**RCW 48.43.515, WAC 284-43-251**
4	**Company standards for selection of participating providers and facilities does not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located high risk geographic areas.**	**WAC 284-43-310(1)(a) and (b)**

INSTRUCTIONS AND RECOMMENDATIONS

The Company passed all standards that were tested. There are no instructions or recommendations as a result of this examination.

SUMMARY OF STANDARDS

Company Operations and Management:

#	STANDARD	PAGE	PASS	FAIL
1	The company is required to be registered with the OIC prior to acting as a health care service contractor in the State of Washington. Reference: RCW 48.44.015(1).	8	X	
2	The company is required to report to the OIC any changes to the registration documents, including Articles of Incorporation, Bylaws, and Amendments at the same time as submitting such documents to the Secretary of State. Reference: RCW 48.44.013.	8	NA	
3	When the company registers with the OIC, it is required to state its territory of operations. Reference: RCW 48.44.040.	8	X	

General Examination Findings:

#	STANDARD	PAGE	PASS	FAIL
1	The company does business in good faith, and practices honesty and equity in all transactions. Reference: RCW 48.01.030.	8	X	
2	The company must facilitate the examination process by providing its accounts, records, documents and files to the examiners upon request. Reference: Reference: RCW 48.03.030(1), RCW 48.44.145(2).	8	X	
3	The company may not discourage members from contacting the OIC and may not discriminate against those members that do contact the OIC. Reference: WAC 284-30-572(2).	8	X	

Claims:

#	STANDARD	PAGE	PASS	FAIL
1	The company shall provide no less than urgent and emergent care to a child who does not reside in the Company's service area. Reference: RCW 48.01.235(3).	10	X	
2	The company shall not retrospectively deny emergency or nonemergency care that had prior authorization. Reference: RCW 48.43.525(1).	10	X	
3	The company shall not retrospectively deny an individual prescription drug claim that had prior authorization. Reference: RCW 48.44.465.	10	X	
4	The company shall not deny benefits for any service performed by a denturist if the service performed was within the lawful scope of such person's license, and the agreement would have provided benefits if services were performed by a dentist. Reference: RCW 48.43.180, RCW 48.44.500.	10	X	

#	STANDARD	PAGE	PASS	FAIL
5	The company shall pay or deny 95% of all claims within 60 days of receipt. Reference: WAC 284-43-321(2).	10	X	
6	The denial of any claim must be communicated to the provider or facility with the specific reason the claim was denied. Reference: WAC 284-43-321(4).	10	X	
7	The company maintains a documented utilization review program with descriptions and conducts utilization review within the prescribed format defined. Reference: RCW 48.43.520, WAC 284-43-410.	10	X	
8	The company administers Coordination of Benefits provisions as required. Reference: Chapter 284-51 WAC.	10	X	
9	All plans must provide female enrollees direct access to women's health care services. Reference: RCW 48.42.100, WAC 284-43-250.	11	X	
10	All plans shall cover emergency services necessary to screen and stabilize a covered person. Reference: RCW 48.43.093.	11	X	
11	Decisions concerning maternity care and services are to be made between the mother and the provider. Reference: RCW 48.43.115.	11	X	
12	An enrollee may receive benefits at a long term care facility if he/she was a resident prior to hospitalization. Reference: RCW 48.43.125.	11	X	
13	All plans must include coverage for diabetes. Reference: RCW 48.44.315.	11	X	
14	All plans must include coverage for mammograms. Reference: RCW 48.44.325, WAC 284-44-046.	11	X	
15	All plans must include coverage for reconstructive breast surgery. Reference: RCW 48.44.330.	11	X	
16	All plans shall waive preauthorization for mental health treatment if member is involuntarily committed to a state mental hospital. Reference: RCW 48.44.342	11	X	
17	All plans must provider coverage for the formula necessary for the treatment phenylketonuria (PKU). Reference: RCW 48.44.440, WAC 284-44-450.	11	X	
18	All group plans shall provide benefits for the treatment of chemical dependency. All contract benefits for the treatment of chemical dependency must comply with the specified standards. Reference: RCW 48.44.420, Chapter 284-53 WAC.	11	X	
19	All group plans must provide benefits for prenatal diagnosis of congenital disorders. Reference: RCW 48.44.344.	11	X	
20	All group plans must provide coverage for neurodevelopmental therapies for individuals age 6 and under. Reference: RCW 48.44.450.	11	X	

#	STANDARD	PAGE	PASS	FAIL
21	All individual health benefit plans offered or renewed after October 1, 2000 shall include maternity and prescription drug benefits. *Individual Coverage Only.* Reference: RCW 48.43.041.	11	X	
22	All plans must include every category of provider. Reference: RCW 48.43.045, WAC 284-43-205.	11	X	

Complaints:

#	STANDARD	PAGE	PASS	FAIL
1	The company has filed a copy of its procedures for review and adjudication of complaints with the OIC. Reference: RCW 48.43.055.	13	X	
2	The company maintains a fully operational, comprehensive grievance process. Reference: RCW 48.43.530.	13	X	
3	The company provides enrollees access to independent review services to resolve disputes. Reference: RCW 48.43.535	13	X	
4	Response to communications from the OIC must be within 15 business days of receipt of the correspondence. The response must contain the substantial information requested by the OIC. Reference: WAC 284-30-650, Technical Advisory T 98-4.	13	X	
5	The company complies with procedures for health care service review decisions. Reference: WAC 284-43-620.	13	X	

Underwriting:

#	STANDARD	PAGE	PASS	FAIL
1	The company complies with the prescribed requirements for enrollment and coverage of a child under the health plan of the child's parent. Reference: RCW 48.01.235, RCW 48.44.212.	14	X	
2	The company appropriately reduces preexisting condition exclusions, limitations, or waiting periods in its large group, small group and individual plans by applying time covered by the preceding health plan coverage. Reference: RCW 48.43.015, WAC 284-43-710.	14	X	
3	The company may not reject an individual for health plan coverage in a large or small group based upon preexisting conditions of the individual. The company may not deny, exclude, or limit coverage for an individual's preexisting health conditions. The company shall accept any state resident within the group and within the company's service area. Reference: RCW 48.43.025, RCW 48.43.035(1), WAC 284-43-720.	14	X	
4	Eligibility to purchase a health benefit plan must be extended to all small employers and small groups as defined in RCW 48.43.005(24). Reference: RCW 48.43.028.	14	X	

#	STANDARD	PAGE	PASS	FAIL
5	Dependent children cannot be terminated from an individual or group plan because of developmental disability or physical handicap. Reference: RCW 48.44.200, RCW 48.44.210.	14	X	
6	All plans shall cover newborn infants and congenital anomalies from the moment of birth. Reference: RCW 48.44.212(1).	14	X	
7	No plan may deny coverage solely on account of race, religion, national origin, or the presence of any sensory, mental, or physical handicap. Reference: RCW 48.44.220.	14	X	
8	The company may not refuse, cancel, or decline coverage solely because of a mastectomy or lumpectomy more than five years prior. Reference: RCW 48.44.335.	14	X	
9	Adoptive children shall be covered on the same basis as other dependents. Reference: RCW 48.44.420.	14	X	
10	An individual is not required to complete the standard health questionnaire if the stated criteria are met. Reference: RCW 48.43.018(1).	14	X	
11	The company shall provide written notice of its decision not to accept an individual's application for enrollment to both the applicant and WSHIP within 15 business days of receipt of a completed application. *Individual Coverage only.* Reference: RCW 48.43.018(2)(b).	15	X	
12	All cancellations, denials, or non-renewals of an individual plan must be in writing and include the reason for such action. Reference: RCW 48.44.260.	15	X	
13	A rider will be cancelled upon application by the enrollee if, at least five years after its issuance, no health care services have been received by the enrollee for the condition specified in the rider. *Individual Coverage only.* Reference: RCW 48.44.430.	15	X	
14	Dependents shall have the right to continue coverage in the event of loss of eligibility by the principal enrollee. Reference: RW 48.44.400.	15	X	
15	All plans shall offer optional coverage for the treatment of temporomandibular joint disorders (TMJ) and maintain proof of offer as required. Reference: RCW 48.44.460, WAC 284-44-042.	15	X	
16	An individual may return an individual health care contract for a full refund within 10 days of its delivery if not satisfied with the contract for any reason. *Individual Coverage Only.* Reference: RCW 48.44.230.	15	X	

Rate and Form Filing:

#	STANDARD	PAGE	PASS	FAIL
1	All contract forms have been filed with and approved by the	15	X	

#	STANDARD	PAGE	PASS	FAIL
	OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.			
2	All rates have been filed with the OIC prior to use. Reference: RCW 48.44.040, WAC 284-43-920.	15	N/A	
3	All contract form and rates have been filed with the OIC on transmittal forms prescribed by and available from the Commissioner. Reference: WAC 284-43-925.	15	X	

Provider Activity:

#	STANDARD	PAGE	PASS	FAIL
1	All provider contract forms must be filed with and approved by the OIC prior to use. Reference: RCW 48.44.070, WAC 284-43-330.	16	X	
2	All provider contract forms must contain and adhere to the prescribed standards. Reference: WAC 284-43-320 through WAC 284-43-340.	16	X	
3	All plans must allow enrollees to select a primary care provider who is accepting new patients from a list of participating providers. Reference: RCW 48.43.515, WAC 284-43-251.	16	X	
4	Company standards for selection of participating providers and facilities does not result in risk avoidance or discrimination by excluding providers or facilities specializing in specific treatments or located in high risk geographic areas. Reference: WAC 284-43-310(1)(a) and (b).	16	X	